Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UMC AT BRACKENRIDGE
1201 LAKE WOODLANDS DR STE 4024
THE WOODLANDS TX 77380

Respondent Name
UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative Box
Box Number: 46

MFDR Tracking Number
M4-13-3090-01

MFDR Date Received
JULY 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Claimant presented at and was treated by the UMC AT BRACKENRIDGE on the date of 7/19/2012-7/20/2012. At that time, hospital staff obtained information concerning THE WORKERS COMPENSATION CARRIER. The charges were billed to UT SYSTEMS on or about the date of 7/20/2012 and MEDICAL RECORDS WERE REQUESTED BY JUANITA PICHLER on the date of 7/30/2012. ON 10/24/2012 WHEN CALLING TO CHECK STATUS THAT IS WHEN WE INFORMED THAT MEDICAL RECORDS HAD BEEN RECEIVED BY THE UB HAD NOT. WE WERE ADVISED TO FAX THIS INFORMATION TO 512-499-5671. ON 11/28/2012 WE RECEIVED A DENIAL FOR TIMELY FILING. WE ARE DISPUTING THIS DENIAL DUE TO THE FACT THAT THE ADJUSTOR REQUESTED MEDICAL RECORDS WHICH MEANS THAT THE UB HAD TO HAVE BEEN RECEIVED AT THAT TIME. ALSO, THE PATIENT WAS NOT DISCHARGED FROM THE HOSPITAL UNTIL 7/20/2012 WHICH WOULD MAKE THE CLAIM SUBMISSION 10/24/2012 A TIMELY SUBMISSION."

Amount in Dispute: $2,257.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carriers' agent responded to the request for medical fee dispute resolution, however, no position summary was included.

Response Submitted by: IMO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 19, 2012 through July 20, 2012	Emergency Services (23 hours)	$2,257.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical

fee dispute.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are July 19, 2012 through July 20, 2012 . The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 22, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 21, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.